Evelyn Weston

Care Promise

Inspection report

Shellam Lodge
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Tel: 01388812340

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 6 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service to people in their own homes. We gave them notice to ensure someone would be at the office at the time of our inspection. The service provides personal care to people who wish to remain independent in their own home across the Durham area. The service could be provided to people with a wide range of needs covering, Learning disabilities or autistic spectrum disorder, Older People, Physical Disability, Sensory Impairment or Younger Adults. At the time of our inspection there was one person using the service. At the last inspection on 29 January 2014 we found the registered provider was meeting the regulatory requirements.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The person who used the service told us they felt safe and well supported by staff.

Staff had received training in safeguarding. We found staff recognised signs of abuse and understood what actions to take if they thought people were unsafe.

There was a process for managing accidents and incidents to ensure the risks of any accidents re-occurring would be reduced.

Staff employed by the registered provider had undergone a number of checks to ensure they were suitable to work in the service; however we found that references on file were not originals and did not have signatures.

Fire risk assessment policies were not being followed and staff did not have clear instructions about what to do in the event of a fire.

Staff had received regular support through supervision and appraisal to enable them to care for people. Mandatory training needs were met but we found that evidence of additional training was required for more specialised tasks.

We saw that the person had person centred support plans that reflected their needs and were reviewed regularly. Support plans reflected the person's needs and preferences.

Individual support plans contained risk assessments. These identified risks and described the measures and interventions to be taken to ensure people were protected from the risk of harm. We found in some case these did not demonstrate that risks had been fully assessed.

The care records showed us that people's health was monitored and health care professionals were involved where necessary for example: their GP, district nurse or social worker.

We saw a compliments and complaints procedure was in place and this provided information on the action to take if someone wished to make a complaint and what they should expect to happen next. People also had access to advocacy services and safeguarding contact details if they needed it.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Any applications must be made to the Court of Protection.

The service adhered to the requirements of the Mental Capacity Act. This meant people's capacity to make decisions had been assessed. Where required we found decisions had been made in people's best interests involving their family members and other professionals.

We found the person who used the service, their representatives and healthcare professionals regularly asked for their views about the service.

We found that spot checks were being introduced but had not previously been used to ensure staff were completing tasks in an appropriate way. Some checks were made on the safety and quality of the service as part of the care review process.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were in place but needed updating to reflect the assessment that had taken place about safe hoisting practices.

Fire evacuation procedures were not in place.

Recruitment checks were in place but were not with the original supporting documents.

Is the service effective?

Good

The service was effective.

We saw that staff received regular support through supervisions and appraisals.

Staff had the training they required to provide care.

People's consent was gained before care was given.

Is the service caring?

Good

The service was caring.

Staff and people who used the service told us that it was caring and staff supported people to remain as independent as possible.

We found that people were given information to make informed choices.

Is the service responsive?

Good

The service was responsive.

People who used the service had person centred support plans describing their care and preferences.

Health professionals were involved in people's care where appropriate.

People told us they knew how to complain and there was a clear process for complaints.

Is the service well-led?

Good

The service was well led.

People who used the service were asked for their feedback about the quality of the service.

Staff told us they had regular contact with management and made positive comments about the nominated individual.

Care Promise

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service to people in their own homes. We gave them notice to ensure someone would be at the office at the time of our inspection.

The inspection team consisted of two adult social care inspectors. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider did not return a PIR because they were considering deregistering the service at the time this was sent. Since then the provider had taken the decision to continue providing a service with a view to increasing the number of people they support. We took this into account when we made the judgements in this report and looked at all of the areas covered by the PIR during our inspection.

Before the inspection we checked the information that we held about Care Promise. For example we looked at safeguarding notifications and complaints. In the 12 months prior to this inspection no notifications or complaints had been received. Care Promise is a very small service and the registered manager confirmed that there had been no events that should have been reported to the Care Quality Commission.

During the inspection we visited the office and spoke to the nominated individual and the registered manager. The service only employed one member of care staff, other than the registered manager, and delivered personal care to one person. We spoke to this staff member and the person who used the service. We reviewed support plans, daily records, two staff training records, two staff recruitment files, quality surveys and records relating to the management of the service, such as policies.

We contacted professionals involved in supporting the person who used the service, including commissioners, an occupational therapist and Healthwatch, no concerns were raised. Healthwatch is an

independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires Improvement

Is the service safe?

Our findings

When we spoke to a person who used the service they agreed that they felt safe having Care Promise supporting them in their own home.

Care Promise had a policy and procedure for safeguarding and whistleblowing. Staff and the person who used the service were aware of how to report abuse. Staff had completed safeguarding training. There had been no recent safeguarding or whistleblowing incidents for the registered provider to respond to. Staff told us they felt confident that they could raise concerns and these would be dealt with by the management.

Staff were able to tell us what actions they would take in the event of a fire, however, there was no documentation to show this had been assessed by the registered provider. Care Promise had a policy titled 'Fire Policy In Service Users' Homes' which stated, "A fire evacuation plan should be agreed as part of the initial health and safety risk assessment in any new home. The plan should be entered in the service user's plan and should note: escape routes, fire risks (smoking habits of service users, use of electric bar fires and evacuation risks. (Is the service user immobile or disabled? Is the evacuation route restricted?)." The policy also said, "Special evacuation arrangements should be made for service users with limited mobility, wheelchairs or sensory impairments." These arrangements were not in place for the person being supported who would require special evacuation arrangements. This meant that the provider could not demonstrate that fire risks had been considered and reduced.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Risk assessments stated that normally two carers were needed to assist with hoisting but a regular carer could complete this task as a lone worker. We discussed this with the staff member and the registered manager who told us this had been assessed as safe practice by an occupational therapist. The service user guide stated, "From time to time Care Support Workers are asked to undertake some tasks which may be considered by our insurers to be specialist. The care support worker would be trained in the procedure before undertaking the tasks by a professional with relevant experience e.g. occupational therapist, speech therapist, pharmacist or nurse, who will sign a form to indicate their competence." The occupational therapist's assessment of the staff member's competency to use the hoist was not kept on file. This mean there was not sufficient evidence on file that it had been assessed as safe practice for the carer to operate the hoist as a lone worker. As part of the inspections we spoke to the occupational therapist that had completed the assessment who confirmed this staff member was competent and that a moving and handling assessment would have been sent to the person who used the service.

It is recommended that the occupational therapist assessment is kept on file and that they be asked to sign a form indicating the staff member's competence because this is what the policy dictates. We asked the registered manager to do this and they agreed to do this immediately. There had not been any accidents and incidents. Policies were in place so there was an agreed process to follow if any accidents or incidents occurred. The registered manager was able to show us how a missed call had been investigated and how

actions had been put in place to prevent this from happening again.

Staff's understanding of human rights was discussed during staff supervision sessions.

Assessments were in place covering risks identified in the environment where the care was being provided. We saw that key safes were considered as part of the assessment. Hoists and other equipment were maintained and the details of the company responsible for servicing the equipment were recorded along with servicing dates.

Detailed risk assessments were in place for specific tasks and had been reviewed. These did not always clearly indicated when staff were providing care and when family were providing care. The registered manager made changes to the risk assessments immediate to rectify this.

The registered manager explained that they would provide care themselves in the event of staff leave or sickness and if this was not possible then agency staff would be used. Staff and the person who used the service confirmed that the registered manager had provided care in the past when the regular carer had been on leave. The registered manager explained that they intend to recruit more staff to provide staffing contingencies but this is dependent on increasing the number of people the service supports.

During the inspection we looked at the recruitment policy and one staff file that showed us that the registered provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, two previous employer references and a Disclosure and Barring Service check (DBS) which was carried out before staff commenced employment. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. The references on file were not originals and had typed signatures, we raised this with the registered manager who explained that the original reference had been e-mailed and accidently deleted. The registered manager confirmed that both referees had been contacted to provide new references.

Care Promise had not taken any staff through disciplinary procedures.

The registered manager and staff member had both received training to administer medicines. Competency assessments were not being completed as medicines administration was not a requirement of the service at the time of the inspection. The registered manager confirmed these would be implemented if staff needed to administer medicines. Staff prepared meals and had completed food hygiene training to do this safely. Care Promise's service user guide stated they provided, "Staff with protective clothing such as disposable gloves & aprons to satisfy regulations relating to Hygiene & Infection control."

Good

Is the service effective?

Our findings

A person who used the service told us, "yes" they were asked their consent before care was given. Comprehensive policies and procedures were in place to guide staff to best practice should these be required. Care files contained consent forms asking the person who used the service for their consent to the care they received.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Any applications must be made to the Court of Protection. At the time of this inspection no applications had been made to the Court of Protection. Staff had received training on the Mental Capacity Act 2005 (MCA), however, there was no one who used the service who lacked capacity to make decisions.

Staff told us, "If I want any training I just ask [the nominated individual]". Staff had training in a range of areas covering: challenging behaviour, fire safety, food hygiene, infection control, medicines administration, Mental Capacity Act, health and safety, safeguarding, moving and handling, emergency first aid and dementia. The training policy stated that these were the mandatory training requirements for all staff.

The registered manager was in the process of establishing a training matrix to monitor training requirements and when training was due for renewal. Training needs were covered as part of the annual appraisal and at supervisions.

A staff member was delivering catheter care and told us that they had received training in this but a certificate had not been provided by the incontinence nurse who provided this training. Staff told us, "The incontinence nurse came and showed me how to do it. The nurse comes every 12 weeks". We saw the support plan for this person which stated, "All care staff must have received appropriate mandatory catheter care training". We spoke to the registered manager about this and they confirmed that they were sourcing accredited training for catheter care. The registered manager could not therefore evidence that the staff member had been signed off as competent to carryout catheter care. The manager assured us that they would organise accredited training for this staff member immediately.

The registered manager showed us the training policy which described the induction process for new staff. Any new staff completed a 12 week induction which included completion of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. During this period staff had a mentor and were given all the policies and procedures relevant to their role. Staff were supported and monitored throughout this period as follows: "Supervision at weeks 4

and 8 to review your progress, then a final induction supervision at week 12, where your employment may become permanent, or extra probation time may be added (up to a further 12 weeks) to address issues which may be below standard." There had been no new staff recruited but we saw that Care Certificate files had been prepared for any new staff to complete.

Staff told us they received regular supervision and felt they were well supported. They told us, "I get time on my own with the [nominated individual], we have meetings and chat about what's happening." We saw that supervision was recorded approximately every three months and included discussion about: safeguarding, promoting independence, dignity and rights, health and safety, confidentially, training, performance and any quality issues. Staff also received an annual appraisal which included a self-assessment by the staff member about difficulties the staff member may have had, for example: what they liked least and most about their job, training needs, aspirations and improvements. Appraisals had last been completed in 2015 but had been planned for 2016.

Staff told us that they regularly spoke to the management. We saw that in the past, when there had been a larger staff team, meetings had been arranged and memos sent to notify staff of significant information. This meant that communication methods were appropriate and adapted depending on the staffing levels.

Good

Is the service caring?

Our findings

Staff and people who used the service told us they thought it was caring. Staff told us, "I love this company; they are good with the clients" and "They go beyond the call of duty". A person who used the service told us, "The care is good and they are very reliable".

We visited a person who used the service's home and saw them interacting positively with staff. We were told that the person who used the service had previously had poor experiences with other care companies but they told us they were "Very happy" with the care being provided by Care Promise. A person who used the service told us that staff had a good relationship with people who used the service. They told us that, "[Staff member] likes to talk about football and the things that I enjoy."

We saw that the person who used the service made decisions about what they wanted to do and when. One person who used the service confirmed that staff asked them about their choices, for example, what they wanted to wear. We saw that assessments asked about people's preferences and how the person's emotional wellbeing would be supported.

Care Promise provided people who used the service with clear and detailed information, including how to contact the office and how to make a complaint. They also gave people information summarising their main policies and procedures.

No one accessing the service needed an advocate. The Service User Guide was given to people who used the service and explained what an advocate is and how to contact one. The Mental Capacity Policy also explains the role of an Independent Mental Capacity Advocate (IMCA) and circumstances when one might be used.

Staff had training in confidentiality and we saw that consent to sharing information forms were in care files. Policies and procedures also explained when staff should and should not share personal information. We saw that support plans explained how privacy and dignity would be maintained, such as, "Staff are to ensure the door and curtains are closed prior to carrying out any catheter care to maintain dignity for [person]"

We saw that the 'objectives of the organisation' as stated in the Statement of Purpose supported "maintaining independence and leading a fulfilling life." We saw this was reflected in support plans, for example, "Service user independence should be encouraged at all times and assistance only given if they are unable to carry out any tasks safely or effectively".

We saw that care records ask people about their wishes at the end of their lives. The assessment asks people to consider, "When I'm dying the following things are important to me". No one who used the service needed end of life care.

Good

Is the service responsive?

Our findings

A person who used the service told us they would tell staff if they had any concerns about their care. They told us, "yes" when asked if they thought staff would resolve any complaints they may have. A staff member told us they had once complained on behalf of the person using the service, "I had to complain, I called the office and it was sorted". The staff member told us this had happened quite a while ago and there were no recent concerns recorded at the office. The service had a compliments and complaints procedure in place. The registered manager and staff were able to demonstrate how they would follow the procedure and deal with complaints. This showed us that the complaints procedure was understood within the service and that there was a process to respond to complaints if any were received.

The support plans that we looked at were very detailed and person centred. 'Person-centred' is about ensuring the person is at the centre of everything they do and their individual wishes and needs and choices are taken into account. The support plans gave details of the person's likes and dislikes, personalised risk assessments and daily routines.

The support plans gave an insight into the individual's personality and preferences, for example they described food and drink preferences. The level of support the person needed to eat and drink was also assessed. Choice was promoted, for example one support plan stated, "Assist to dress ensuring [person] is offered a choice of clothing Support plans asked if people had any cultural preferences, for example in relation to their personal care. Support plans prompted staff to ensure the person was dressed appropriately for the weather and to take opportunities when completing personal care to check the person's skin for any signs of pressure damage, with the person's agreement. They also stated actions staff should take to ensure the person was comfortable.
Support plans and risk assessments had been reviewed to ensure they reflected people's current needs.

We saw people were involved in developing their own support plans. We also saw other people that mattered to them were involved in developing their support plans too. People were given a timetable so they knew when to expect their carers to arrive and the agreed care tasks that would be carried out.

The person's emotional wellbeing and communication needs had been assessed. Although social activities were not a feature of the care being provided support plans stated staff should "have a chat" to the person using the service. This showed consideration had been given to the person's need for interaction with staff to prevent social isolation.

Care files included contact details for the professionals involved such as district nurses, occupational therapists and general practitioners (GPs). Support plans detailed the level and frequency of input these professionals had in the services.

Good

Is the service well-led?

Our findings

The service had an up to date statement of purpose, this is a document which tells people and their relatives what they can expect from the service. People who used the service also received a service user guide setting out how the service operates and who to contact in relation to the service.

We spoke to the nominated individual who was also the owner of Care Promise. The nominated individual told us, "Because we are a small company people really care". They explained they would like to grow the business but would do this in a way that maintained its quality. We saw an organisational structure chart demonstrating what the staffing structure would look like if the staff team increased.

Care Promise employed a registered manager who had been registered since 22 December 2015. They told us that since starting in this role they had focused on getting policies and procedures, the statement of purpose and service user guide up to date. They had also reviewed support plans and risk assessments. The policies and procedures reflected that consideration had been given to quality assurance processes but due to the size of the service most of these processes had not yet been required. The registered manager had not completed audits for complaints, compliments, safeguarding, incident and accidents as none had been received. Prior to the registered manager being appointed the service had been managed by the nominated individual. Staff we spoke with told us they were supported by the nominated individual. Staff told us, "I can call them, they are a good boss".

The registered manager told us, "Our overall aim is to provide high quality care to help people remain in their own homes, to promote independence and to let them carry out what they can do themselves".

The registered manager also told us that they were trying to create wider community awareness of the service. They have shared promotional material with GPs, Social Services and local charities.

The registered manager told us they had developed a process for spot checks but this was not yet being used in the service we visited. It did however appear that checks were made on the service as part of the review process and a staff member told us, "They come out about every six months" and, "They come and check the hoist, bed and find out any feedback from [person]".

Care Promise had previously provided support to other people and although these arrangements had ended they were able to demonstrate that there was a process where any new care was closely monitored. This monitoring involved asking questions to ensure the person was happy with the service such as, "The efficiency of the Care Promise representative in dealing with your referral", "The speed in which the care support worker was introduced and the care started" and "How well the care support worker meets you needs". The person who used the service had rated their experience as "good." We saw that Care Promise had also asked for feedback from the service commissioner who had told them, "I went to see [person] yesterday, very happy with service especially how you keep in touch with [person]".

We saw that people who used the service were asked for their feedback on a regular basis. Annual surveys

and six monthly reviews had been completed by people who used the service and their relatives. These asked questions about the quality of the service, the punctually of staff, how staff met needs and prompted independence. Feedback from these was positive.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Fire risk assessment/evacuation plans were not in place for a person who required hoisting.